[redacted]

☐ Attachment Indicator

PAYMENT ADJUSTMENT REQUEST

FORM NUMBER
12 34 56
SDH-DHCF (PA-1) 8/92

UTAH DEPARTMENT OF HEALTH
MEDICAID FORM

1. Adjustment is for ☐ Underpayment ☐ Overpayment

2. Provider Name and Address

4. Claim Number (TCN)

REQUEST THAT A PAYMENT ADJUSTMENT BE MADE FOR:

3. Provider Number

5. Recipient Last Name, First

6. Recipient ID Number

8. R/A Number

9. R/A Date

7. Patient Account Number

10. Explain Reason for Adjustment

11. Dates of Service		12. Days or Units	13. TOS	14. Procedure			15. Explanation of Unusual Services or Circumstances	16. Debit/Credit	17. Charges	FOR STATE USE ONLY
FROM	TO			CODE	MOD	MOD				

20. Total Amount

21. Third Party Liability Payment Received

22. Net Adjustment

18. Provider Signature:

19. Date:

23. Explanation of payment or denial (To be completed by Department of Health)

24. Approval Adjustment Accounting Code

25. Denied ☐

26. Clerk I.D.

27. Signature of Approving Authority

28. Date
MM/DD/YY

Instructions for the Payment Adjustment Request Form

If a claim was denied because of incorrect information submitted, call Medicaid Information to correct the claim. Do NOT use a Payment Adjustment Request Form. This will expedite processing and payment. For example, Medicaid staff can correct incorrect procedure codes and/or units of services, such as number of days or quantity.

Use this form to request an adjustment to payment of a claim previously submitted. Examples include (1) claim denied which may be payable if additional documentation is sent for review, such as a claim for a recipient of Emergency Services Only; (2) claim denied because it exceeds the billing deadline*****; (3) adjust a physician claim for additional payment using Modifier 22; (4) report an overpayment and refund the amount overpaid. ******

When a Payment Adjustment Form is processed, claims which are either paid or denied appear in the paid or denied section of the Remittance Statement.

*** Claim denied because of billing deadline**

Reference: Utah Medicaid Provider Manual, SECTION 1, Chapter 11 - 10, Time Limit to Submit Medicaid Claims

You must have documentation to prove one of the reasons stated in SECTION 1, Chapter 11 - 13 Requesting Review of Claim That Exceeds Billing Deadline. If so, follow instructions below:

1. Enter the Transaction Control Number (TCN) of the denied claim in Field 4.
2. Explain the reason for the delay and why the services should be considered for payment in Field 10.
3. Mail the completed form and appropriate documentation to BUREAU OF MEDICAID OPERATIONS
BOX 143106
SALT LAKE CITY UT 84114-3106

**** Report an overpayment to Medicaid and refund the amount overpaid**

1. Make a check payable to Medicaid for the overpayment.
2. Enclose either a Payment Adjustment Request form* or a copy of the remittance statement with a circle around the TCN number of the claim you want to correct.
* Payment Adjustment Request Form: Get a copy from the Medicaid Internet site www.health.state.ut.us/medicaid/PAR.pdf ; or the General Attachments section of the Utah Medicaid Provider Manual; or call Medicaid Information.
3. Write the reason for the overpayment on the remittance statement or Payment Adjustment Request. Possible reasons include third party payment, duplicate payment, or credit balance (if there was a CR on your remittance statement).
4. Mail the check and form to: Office of Recovery Services, Medicaid Section, Team 85, P. O. Box 45025, Salt Lake City UT 84145

ITEM NUMBER (Items in bold are mandatory)	INSTRUCTION
☐ Attachment indicator	Check if additional information is attached.
1. Adjustment is for:	Check box to indicate the type of adjustment to be made.
2. Provider Name and Address:	**Enter name and address of provider.**
3. Provider Number	**Enter twelve digit Provider Identification Number as shown on claim.**
4. Claim Number (TCN)	**Enter the Transaction Control Number (TCN) of the claim to be adjusted.**
5. Recipient Last Name, First	**Enter the name of Medicaid recipient for which the payment adjustment is requested.**
6. Recipient ID Number	**Enter the Medicaid Identification Number of recipient.**
7. Patient Account Number	Enter the Medicaid recipient's patient account number.
8. R/A Number	Enter the Remittance Advice number, found in the upper left hand corner of the remittance statement.
9. R/A Number	Enter the Remittance Advice Number.
10. Explain Reason For Adjustment	**Enter a narrative explanation of reasons the adjustment is needed.**
11. Dates of Service	**Enter the date of service.**
12. Days or Units	Enter the total units administered during service.
13. TOS	NOT APPLICABLE
14. Procedure	**Enter the procedure code with its modifiers when necessary.**
15. Explanation of Unusual Services or Circumstances	Complete the explanation of circumstances. Additional information may be attached.
16. Debit/Credit	Enter the word 'debit' or 'credit' when applicable.
17. Charges	Enter the total charges for services rendered, including the adjustment amount.
18. Provider Signature	Self-explanatory
19. Date	Date of signature
20. Total Amount	Enter the total amount of charges for services provided.
21. Third Party Liability Payment Received	Enter the amount received from any third party.
22. Net Adjustment	Enter the total amount minus third party payment received.
23. - 28.	FOR STATE USE ONLY